

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/23/2011	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaint IN00095160.</p> <p>Complaint IN00095160- Substantiated, federal/state deficiencies related to the allegations are cited at F282, F333, and F371.</p> <p>Survey date: August 23, 2011</p> <p>Facility number: 000005 Provider number: 155005 AIM number: 100270840</p> <p>Surveyor: Jeri Curtis, RN</p> <p>Census bed type: SNF: 21 SNF/NF: 141 Total" 162</p> <p>Census payor type: Medicare: 21 Medicaid: 121 Other: 20 Total: 162</p> <p>Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>			F0000	<p>September 9, 2011 Long Term Care Division, 4 th Floor2 North Meridian StreetIndianapolis, IN 46204 RE: ManorCare Health Services of Anderson 1345 N. Madison Ave. Anderson, IN 46011 Dear Kim</p> <p>Rhoades: Enclosed is our Plan of Correction and credible allegation of compliance for our complaint survey completed on September 22, 2011. If you should have any other questions or need additional information, please contact me at the above address or phone numbers. You may also contact me via email at 421admin@hcr-manorcare.com.</p> <p>Sincerely, Nicole Fields, HFAAdministrator</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0282 SS=D	<p>Quality review completed on August 29, 2011 by Bev Faulkner, RN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure physicians' orders were followed for the administration of an anti-glycemic to control blood sugar levels, and for a narcotic and analgesic patch for pain management. This affected 2 (Residents B and C) of 4 residents among the sample of 4, reviewed for physician orders.</p> <p>Findings include:</p> <p>During the 8/23/11, 9:20-11:30 A.M., entrance tour, Licensed Practical Nurses #1 and #2, were observed passing medications on the Family Tree unit.</p> <p>LPN #1 was interviewed at 10:20 A.M., 8/23/11, and indicated she was still passing the 8:00 A.M., medications. LPN #1 indicated she had to stop and monitor the dining room at breakfast which had delayed the medication pass. LPN #1 also indicated she had not worked the unit for some time and was not familiar with the</p>			F0282	<p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u> Diabetic Management review completed for resident B including medications and labs. Results reviewed by Primary Care Physician. Resident's stock of medications reviewed to ensure medications are available for administration per the physician's order. Pain management review completed for resident C. Results reviewed by Primary Care Physician. One on one education completed with LPN # 1 and #2 on medication pass guidelines to include completion within 60 minutes before or after the ordered time. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</u> All residents receiving medication have the potential to be affected by the same deficient practice. Licensed staff will be educated on the Medication Administration</p>		09/22/2011

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	<p>residents.</p> <p>LPN #1 indicated the facility policy was for medications to be administered within 1 hour on either side of the scheduled hour. LPN #1 indicated she was at the end of the pass, with 3 more residents who still required 8:00 A.M. medications.</p> <p>Observation of the administration of the 8:00 A.M., medications to Resident (B), by LPN #1 was observed at 10:35 A.M., 8/23/11. The medications included the anti-glycemics, Glucophage 1500 milligrams (mgs) to be given every 8:00 A.M., daily, and Glimepiride 4 mgs to be given twice daily.</p> <p>The Glucophage was not stocked in the unidosage box of Resident (B). LPN #1 circled the medication and indicated she would obtain the Glucophage and administer it later.</p> <p>LPN #2 was observed passing medications on another hall on Family Tree at 10:58 A.M. Observation of the 8:00 A.M., medication pass to Resident (C) was observed at 10:58 A.M., 8/23/11. The medications included Morphine Sulfate Extended Release 30 mg, scheduled at 8:00 A.M., and 8:00 P.M., and Ben Gay pain relief patch, scheduled on at 8:00 A.M., and off at 8:00 P.M. LPN #2 indicated Resident (C) needed the medications before his morning care. LPN</p>				<p>Guidelines. <u>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur</u>; A review of the staffing pattern and workload was completed and presented to QA&A Committee for review and approval of changes.</p> <p>Adjustments to the Family Tree and Intermediate Unit include an additional medication cart and nurse to facilitate completion of the medication pass within the guidelines. Licensed staff will be educated on the Medication Administration Guidelines to include completion within the 60 minutes before and after scheduled medication times and physician notification if unable to complete medication pass. Nurses will also be educated regarding utilization of the Emergency Drug Kit as a back up if medications are not in stock for a specific resident to ensure medications are delivered per the physician's order. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place</u>;</p> <p>Medication Administration observations will be conducted on all shifts for a total of 12 observations a week times four weeks with findings presented weekly to the QA & A</p>		

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	<p>#2 indicated Resident (C) had refused morning care until the medications were received.</p> <p>The record of Resident (B) was reviewed at 11:50 A.M., 8/23/11, and indicated diagnoses including Diabetes Mellitus II. On 1/28/10, the physician had ordered Glimepiride 4 mg, twice daily. On 8/21/11, the physician had ordered Glucophage 1500 mg every morning (8:00 A.M.) and 1000 mg every 4:00 P.M. A 5/26/10, care plan concern of an endocrine system need for monitoring related to insulin dependent diabetes and uncontrolled glucose readings, had been reviewed with a goal target date of 10/20/11. Interventions included administering medications as per MD (physician) orders.</p> <p>The record of Resident (C) was reviewed 8/23/11, at 11:35 A.M. Diagnoses included chronic pain syndrome, osteoarthritis, a right below the knee amputation (AKA) and a non-healing surgical wound.</p> <p>The physician orders included 6/14/11, Ben Gay Ultra Strength patch to be applied topically to right hip, on 12 hours(8:00 A.M.) and off 12 hours (8:00 P.M.), and 6/17/11, Morphine sulfate ER (extended release) twice daily (8:00 A.M., and 8:00 P.M.).</p>				<p>committee for review. Observations will continue for a minimum of six months. QA & A committee will review findings and determine need for further monitoring and education per the QA & A process.</p>		

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	<p>The 1/13/11 plan of care,had been reviewed with a goal target date through 10/26/11, indicating a pain risk evidenced by complaint of pain related to immobility. Interventions included administering the pain medication as per MD orders and note effectiveness.</p> <p>A 9/26/10 care plan concern was resident experiences phantom pain related to AKA, with a 10/29/11, target goal of analgesia will not affect participation in daily care.</p> <p>During an 8/23/11, 3:00 P.M., interview, the Director of Nursing (DoN) indicated facility protocols required the plan of care be followed for each resident.</p> <p>The DoN provided the facility's 3/10 "Medication Administration: Medication Pass Policy" on 8/23/11.</p> <p>Point #9 indicated medications were to be in accordance with frequency prescribed by the physician-within 60 minutes before or after prescribed dosing time.</p> <p>This federal tag relates to Complaint IN00095160.</p> <p>3.1-35(g)(2)</p>						

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F0333 SS=D	<p>The facility must ensure that residents are free of any significant medication errors. Based on observation, record review, and interview, the facility failed to ensure anti-glycemics to control blood sugar levels, and a narcotic, and analgesic patch for pain management, were administered on the scheduled times ordered by the physicians for 2 (Residents B and C) of 4 residents in a sample of 4 reviewed for medication administration. This deficient practice provided a potential for hypoglycemia (Resident B) and uncontrolled pain (Resident C).</p> <p>Findings include:</p> <p>During the 8/23/11, 9:20-11:30 A.M., entrance tour, Licensed Practical Nurses #1 and #2, were observed passing medications on the Family Tree unit.</p> <p>LPN #1 was interviewed at 10:20 A.M., 8/23/11, and indicated she was still passing the 8:00 A.M., medications. LPN #1 indicated she had to stop and monitor</p>		F0333	<p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u> Diabetic Management review completed for resident B including medications and labs. Results reviewed by Primary Care Physician. Resident's stock of medications reviewed to ensure medications are available for administration per the physician's order. Pain management review completed for resident C. Results reviewed by Primary Care Physician. One on one education completed with LPN # 1 and #2 on medication pass guidelines to include completion within 60 minutes before or after the ordered time. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</u> All residents receiving medication have the potential to be affected by the same deficient practice.</p>		09/22/2011	

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	<p>the dining room at breakfast which had delayed the medication pass. LPN #1 also indicated she had not worked the unit for some time and was not familiar with the residents.</p> <p>LPN #1 indicated the facility policy was for medications to be administered within 1 hour on either side of the scheduled hour. LPN #1 indicated she was at the end of the pass, with 3 more residents who still required 8:00 A.M. medications.</p> <p>Observation of the administration of the 8:00 A.M., medications to Resident (B), by LPN #1 was observed at 10:35 A.M., 8/23/11. The medications included the anti-glycemics, Glucophage 1500 milligrams (mgs) to be given every 8:00 A.M., daily, and Glimepiride 4 mgs to be given twice daily (8:00 A.M., and 8:00 P.M.).</p> <p>The Glucophage was not stocked in the unidosage box of Resident (B). LPN #1 circled the medication and indicated she would obtain the Glucophage and administer it later.</p> <p>LPN #2 was observed passing medications on another hall on Family Tree at 10:58 A.M. Observation of the 8:00 A.M., medication pass to Resident (C) was observed at 10:58 A.M., 8/23/11. The medications included Morphine Sulfate Extended Release 30 mg,</p>				<p>Licensed staff will be educated on the Medication Administration Guidelines. <u>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur</u>; A review of the staffing pattern and workload was completed and presented to QA&A Committee for review and approval of changes. Adjustments to the Family Tree and Intermediate Unit include an additional medication cart and nurse to facilitate completion of the medication pass within the guidelines. Licensed staff will be educated on the Medication Administration Guidelines to include completion within the 60 minutes before and after scheduled medication times and physician notification if unable to complete medication pass. Nurses will also be educated regarding utilization of the Emergency Drug Kit as a back up if medications are not in stock for a specific resident to ensure medications are delivered per the physician's order. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place</u>;</p> <p>Medication Administration observations will be conducted on all shifts for a total of 12 observations a</p>		

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	<p>scheduled at 8:00 A.M., and 8:00 P.M., and Ben Gay pain relief patch, scheduled on at 8:00 A.M., and off at 8:00 P.M. LPN #2 indicated Resident (C) needed the medications before his morning care. LPN #2 indicated Resident (C) had refused morning care until the medications were received.</p> <p>LPN Unit Manager #1 was interviewed at 11:00 A.M., 8/23/11, and indicated if a nurse found herself out of compliance with administration times, which happened from time to time, the physician and responsible party of the resident were to be notified. LPN Unit Manager #1 indicated usually the medication hours were shuffled or adjusted with the other medication times.</p> <p>LPN Unit Manager #1 indicated the current census on the unit was 58, with 3 licensed nurses on duty on days for medication administration. LPN Unit Manager #1 indicated the halls were split and each nurse had 18-19 residents for medication administration.</p> <p>The record of Resident (B) was reviewed at 11:50 A.M., 8/23/11, and indicated diagnoses including Diabetes Mellitus II. On 1/28/10, the physician had ordered Glimepiride 4 mg, twice daily (8:00 A.M., and 8:00 P.M.).</p> <p>On 8/21/11, the physician had ordered</p>				<p>week times four weeks with findings presented weekly to the QA & A committee for review. Observations will continue for a minimum of six months. QA & A committee will review findings and determine need for further monitoring and education per the QA & A process.</p>		

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	<p>Glucophage 1500 mg every morning (8:00 A.M.) and 1000 mg every 4:00 P.M.</p> <p>A 5/26/10, care plan concern of an endocrine system need for monitoring related to insulin dependent diabetes and uncontrolled glucose readings, had been reviewed with a goal target date of 10/20/11.</p> <p>Interventions included administering medications as per MD (physician) orders.</p> <p>The record of Resident (C) was reviewed 8/23/11, at 11:35 A.M. Diagnoses included chronic pain syndrome, osteoarthritis, a right below the knee amputation (AKA) and a non-healing surgical wound.</p> <p>The physician orders included 6/14/11, Ben Gay Ultra Strength patch to be applied topically to right hip, on 12 hours(8:00 A.M.) and off 12 hours (8:00 P.M.), and 6/17/11, Morphine sulfate ER (extended release) twice daily (8:00 A.M., and 8:00 P.M.)</p> <p>The 1/13/11 plan of care had been reviewed with a goal target date through 10/26/11, indicating a pain risk evidenced by complaint of pain related to immobility. Interventions included administering the pain indication as per MD orders and note effectiveness.</p> <p>A 9/26/10 care plan concern was resident experiences phantom pain related to AKA, with a 10/29/11, target goal of</p>						

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	<p>analgesia will not affect participation in daily care.</p> <p>On 8/23/11, the Director of Nursing (DoN) provided the facility's pharmacy, Omnicare, hand-outs from the website,(omniview.omnicare.com/na/apps/Web/DrugInfo/DrugImprint.aspx?impelD-6061, and 6309) on drug information. The DoN indicated the facility used the Omnicare website as a drug reference for dosage, potential side effects, and contraindications for crushables and drug interactions.</p> <p>The DoN indicated the licensed nurses were also allowed to use any supplemental drug reference of their own.</p> <p>The Lexi-Comp Drug Information Handbook for Nursing, 2009, edition, drug factor information on Amaryl (Glimepiride), a Sulfonylurea, was reviewed. The warning information indicated all Sulfonylurea drugs are capable of producing severe hypoglycemia. Hypoglycemia was more likely to occur when caloric intake was deficient.</p> <p>The meal times for the Family Tree unit had been provided by the DoN. Breakfast was at 7:45 A.M., and lunch at 12:15 P.m.</p> <p>The DoN had also provided the facility's</p>						

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F0371 SS=F	3/10, Medication Administration: Medication Pass Policy on 8/23/11. Point #9 indicated medications were to be in accordance with frequency prescribed by the physician-within 60 minutes before or after prescribed dosing time. This federal tag relates to Complaint IN00095160. 3.1-48(c)(2)						
	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to foods and beverages not covered with lids or plastic wrap when trays were transported through resident care and public areas.			F0371	<u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u> No residents were specifically identified as being negatively affected by the		09/22/2011

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	<p>This had the potential to affect 162 residents who consumed meals from the facility's kitchen out of a total population of 162 residents.</p> <p>Findings include:</p> <p>The 8/23/11, meal service to the front dining room was observed at 12:25 P.M. Three nursing staff members obtained select meal orders from the 24 residents and took these to the kitchen, which was 10 feet across a public entrance hall. The meal service started after the select menu orders were received. Each of the three staff members were observed to carry a tray, do a meal set-up, then return for another tray. The main entrees were covered with a lid. None of the other food items nor beverages were covered. Silverware was wrapped in a napkin.</p> <p>Dietary Aide #1, who was assisting with the front dining room service from the kitchen, was interviewed at 12:30 P.M., 8/23/11. Dietary Aide #1 indicated the room trays were not covered if sent in a closed cart. Dietary Aide #1 indicated if a tray went out on an open cart, the food items were covered with Saran. Dietary Aide #1 indicated the food items on the trays served to the front dining room were not covered because it was just a few feet across the hall.</p>				<p>deficient practice. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</u> Residents who consume meals from the facility kitchen have the potential to be affected by the same deficient practice. Dietary and nursing staff will be educated on the necessity to cover food and beverages during transport. <u>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur:</u> Food and beverages transported through resident care and public areas will be covered. Education will be completed with dietary and nursing staff regarding covering food and beverages during transport. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place:</u> Food Service Manager or designee will monitor compliance weekly via using attached audit tool. Please see exhibit A. Observations will continue for a minimum of six months. QA & A committee will review findings and determine need for further monitoring and education per the QA & A process.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155005		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 08/23/2011	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1345 N MADISON AVE ANDERSON, IN46011			
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	<p>The meal tray of Resident (A), who was eating in the room on the intermediate unit, was observed at 12:35 P.M., 8/23/11. Saran wrap was observed over the juice and fruit cup. Resident (A) indicated he always ate in the room and usually only the entree was covered.</p> <p>The lunch meal pass to resident rooms on the intermediate care unit was observed at 12:40 P.M., 8/23/11. Eighteen lunch trays were observed in a cart which had closed doors on each end. The entrees were covered with a pod lid. The beverages, milk, juice, coffee, or tea, were not covered. The fruit cups were not covered with Saran or other type of covering. The chocolate cake was not wrapped with Saran, nor covered in any way. Silverware was wrapped in a napkin. CNA #1 was observed to move the cart from room to room, pass, and set up each resident tray, before moving to the next. CNA #2 was observed to carry trays the length of the hall to resident rooms. CNA #1 was interviewed during the meal service pass and indicated sometimes Saran was placed over foods and beverages and sometimes not. CNA #1 indicated there had been 19 room trays on the unit and the cart held only 18. CNA #1 indicated the room tray for Resident (A) had arrived on an open cart, which held a</p>						

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	<p>coffee dispenser and cups. CNA #1 indicated the foods and beverage of Resident (A) had been covered with Saran wrap because it had arrived on the open cart.</p> <p>Day Cook #1, who worked in the main kitchen, was interviewed at 1:00 P.M., 8/23/11, and indicated if a tray was served to the front dining room across the hall, food items were not covered. Day Cook #1 indicated if a tray went out on an open tiered cart, food items were covered. Day Cook #1 indicated oatmeal and soup were exceptions, and were always covered whether they went out on a cart or were served to a dining room.</p> <p>The room tray and dining room meal pass to the back, Family Tree unit, was observed at 1:05 P.M., 8/23/11. The room trays were on a closed cart. The entrees were covered, the beverages, fruit cups, and chocolate cake, were not covered. Silverware was wrapped in a napkin. Four room trays on an open tiered cart, were covered with Saran and the silverware was wrapped in a napkin. The trays which were served from the hot plate window to the Family Tree dining room, which was immediately adjacent, were covered with pod lids, Saran wrap, and cup lids. Silverware was wrapped in a napkin.</p>						

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	<p>Dietary Manager #1 was interviewed at 3:20 P.M., 8/23/11. Dietary Manager #1 indicated all food items were to be covered with pod lids, Saran, or cup lids, when transported.</p> <p>The Director of Nursing (DoN) provided the facility's 4/06, Tray Service and Transport Policy on 8/23/11. Point #6 of the guidelines indicated trays were transported in an enclosed cart whenever possible. Foods, beverages, and eating utensils were to be covered with lids, plastic wrap, or other suitable covering if trays were carried through patient care and public areas. Point #10 indicated tray transport carts were to be moved from room to room to minimize exposure to the air outside resident rooms. Point #12 indicated capping beverages might minimize spillage.</p> <p>This federal tag relates to Complaint IN00095160.</p> <p>3.1-21(i)(3)</p>						